

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-042943

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 1399

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

FILED REC 16 1963

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Joseph,		c. CITY OR TOWN St. Joseph,	
Length of stay in lb 30 years		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Meth. Hosp. & Med. Center		d. STREET ADDRESS (If outside, give location) 716 Logan Street	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ARTHUR Middle V. Last FOX		4. DATE OF DEATH Month December Day 6, Year 1963	
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH Feb. 7, 1904
9. AGE (last birthday) 59		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Floor Manager		10b. KIND OF BUSINESS OR INDUSTRY Sheridan Clayton Paper Co.	
11. BIRTHPLACE (City and state or country) Morristown, Tenn.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Jim Fox		13b. MOTHER'S MAIDEN NAME Ellen Quinton	
14. NAME OF HUSBAND OR WIFE Catherine Fox		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W.W. #2	
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Catherine Fox-St. Joseph, Missouri	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>nephrosis</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>amyloid disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		INTERVAL BETWEEN ONSET AND DEATH 3 yrs 6 mo 3 yrs 6 mo	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>3-20-61</u> to <u>12-6-63</u> and last saw him alive on <u>12-6-63</u> Death occurred at <u>5:20 PM</u> m on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Deedee or title) H.C. Senne MD	
22b. ADDRESS 223 N 7th St. Joseph Mo		22c. DATE SIGNED 12-7-63	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE Dec. 10, 1963	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.	
23d. LOCATION (City, town, or county) St. Joseph, Missouri		23e. DATE RECD. BY LOCAL REG. Dec. 12, 1963	
24. FUNERAL DIRECTOR Meierhoffer-Fleeman Inc., St. Joseph, Mo.		25. REGISTRAR'S SIGNATURE Mrs. Clark Goodell	

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

H.C. Senne, MD Medical Certification

210711-003

JAN 28 1964

Permit issued 12-9-63
2114
2114
0-1-4

0-2

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Robert R. Harrington

Licensed Embalmer No. 2268

P. O. Address St. Joseph, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.